K. HEALTH CARE UPDATE

by
Judith E. Kindell and T.J. Sullivan

1. Introduction

In the two years since the last CPE article discussing general health care issues, the tax exempt health care industry has continued to evolve. The focus of this article will be on administrative and legal developments during the past two years affecting tax exempt health care organizations. However, one of the most important developments during this period, recognition of integrated delivery systems as exempt from federal income tax under IRC 501(c)(3), are discussed in a separate topic in this text and in the 1994 EO CPE text.

In addition, there have also been legislative developments in the health care area. For example, the Clinton Administration's health care reform proposal recognizes the continuing need for hospital tax exemption. It would adopt the existing community benefit standard for hospital tax exemption and build on that by requiring IRC 501(c)(3) organizations that provide health care to prepare a community benefit plan with meaningful community participation as a condition for tax exemption. In addition, the Treasury Department has developed a proposal for intermediate sanctions in response to hearings held by the Subcommittee on Oversight of the House Ways and Means Committee. The proposal would provide for an excise tax on excess benefits provided to insiders by IRC 501(c)(3) organizations. The excise tax also would be applied to IRC 501(c)(4) organizations such as HMOs.

Because the health care reform debate is ongoing, and the final contours of what will be enacted are unclear, this topic will not focus on the various proposals being discussed by Congress.

2. ISP Team

As a result of the high interest in health care issues by Congress, the Service, and the public, the Exempt Organizations Health Care Industry Specialization Program (ISP) was revised in early 1994.

The EO Health Care ISP was established on October 1, 1990. Each ISP consists of a team that coordinates selected issues common to the industry and

assists in resolving those issues uniformly and consistently among all industry taxpayers. The teams are led by an Industry Specialist who helps channel communication between the Field and the National Office for better identification and development of issues.

The 1994 EO Health Care ISP Team is unique in that it is co-led by an Industry Examination Specialist based in the Field and an Industry Technical Specialist based in the National Office. Fred Kluss, an EP/EO Specialist in Chicago, is the Industry Examination Specialist and T.J. Sullivan, Special Assistant to the Assistant Commissioner (EP/EO) for Health Care in Washington, DC, is the Industry Technical Specialist. These individuals, as well as other team members, are available to assist agents working cases in the health care industry.

In an effort to provide closer coordination between the Field and National Office, the EO Health Care ISP team members are increasing their efforts to meet on-site with agents working on health care issues. This includes agents working on non-CEP audits of health care organizations as well as the agents working on the CEP hospital audits. Mr. Kluss expects to visit each CEP hospital audit at least once during the examination accompanied by Mr. Sullivan or one of the other Technical members of the ISP team. During visits, ISP representatives will try to meet with other EP/EO agents working CEP or non-CEP health care cases.

In addition, the EO Health Care ISP team will continue to work closely with the Examination Health Care ISP. All individuals and taxable, for-profit, or investor-owned entities in the health care industry are included in Examination's Health Care ISP. Examination's Health Care Industry Specialist is John Tucker, a Revenue Agent based in Nashville. The Examination team works with the EO team to provide comprehensive coverage of the industry and coordination with respect to overlapping issues.

Recently, the Examination and EO Health Care ISP teams cooperated on the development of an internal training course through the IRS Corporate Education initiative. This course, Introduction to the Health Care Industry, explored topics of interest to both Examination and EO agents, as well as covering topics of special interest to each in separate sessions. The course and the associated textbook are expected to be finalized and available by the beginning of FY 1995.

3. Health Maintenance Organizations

A. General

Although health maintenance organizations (HMOs) have been in existence for a number of years, in recent years they have increased in popularity. HMOs come in a variety of models, typically known as the staff model, the group model, the network model, the IPA model, and the mixed model. In a "staff model" HMO, care is provided in a central location by physicians and others working as salaried employees of the HMO. Care is also provided in a central location in a "group model" HMO, although it is provided by physicians in an existing group practice that contracts exclusively with the HMO. There is the "network model" HMO, in which care is provided under contract by a network of groups and physicians practicing independently. The most common model is the "IPA model" HMO, in which care is provided by physicians practicing individually in their own offices who contract with the HMO through an intervening individual practice association (IPA). Finally, HMOs may also operate in a manner that combines characteristics of the various models. These are known as "mixed model" HMOs.

About two-thirds of existing HMOs are for-profit organizations, but some nonprofit HMOs may qualify for exemption from federal income tax under either IRC 501(c)(3) or IRC 501(c)(4). The Service recognizes an HMO as exempt under IRC 501(c)(3) provided it meets the Sound Health test, based on Sound Health Ass'n v. Commissioner, 71 T.C. 158 (1978), acq., 1981-2 C.B. 2. In Sound Health, Tax Court held that the staff model HMO in question qualified for exemption under IRC 501(c)(3). Noting that the provision of health care is a charitable activity, the court stated that the standards used for determining the exempt status of hospitals have relevance to the exemption of HMOs. The court looked to Rev. Rul. 69-545, 1969-2 C.B. 117, in which the Service set forth the rationale used to determine whether hospitals primarily serve a charitable purpose, and determined that the organization had virtually all the characteristics of the hospital that was approved for exemption in that revenue ruling. The court focused on the delivery of health care services by the organization to the community. Because an almost unlimited number of persons were eligible for care at the organization's facility, the court did not accept the Service's argument that the organization was primarily operated for the benefit of subscribers.

The Service acquiesed in Sound Health in 1981-2 C.B. 2. The rationale for the acquiescence is set out in G.C.M. 38735 (May 29, 1981). Thus, the Service's position is that an HMO operated in a manner similar to the organization in Sound Health may qualify for exemption under IRC 501(c)(3). In general, this means that virtually all successful HMO applicants for IRC 501(c)(3) exemption will be organized on the staff model and should share enough of the characteristics of the

organization in Sound Health to ensure that they operate to benefit the community as a whole and not merely their subscribers. The determination whether an HMO primarily benefits the community as a whole depends upon all the facts and circumstances, but obviously, the more factors the HMO has in common with the Sound Health organization, the better the case for a favorable determination.

B. Provider vs. Non-Provider

The Service has denied tax exemption under IRC 501(c)(3) to HMOs that are not operated on the staff (and, in some cases, captive group) model. However, non-staff model HMOs may qualify for tax exemption as social welfare organizations described in IRC 501(c)(4). In the case of the two organizations discussed in G.C.M. 39828 (Aug. 30, 1990), neither was a staff-model HMO and neither was found to be charitable after resort to the analysis set forth above. Likewise, the IPA-model HMO in G.C.M. 39057 (Nov. 9, 1983), was determined not to qualify for IRC 501(c)(3) exemption. Further, in Geisinger Health Plan v. Commissioner, 985 F.2d 1210 (3rd Cir., 1993), rev'g 62 TCM 1656 (1991), the court agreed with the Service's contention that the non-staff model HMO in question did not qualify for IRC 501(c)(3) exemption under the Sound Health test.

In Geisinger, an HMO ("GHP") qualified under both state and federal law operates as a subordinate entity in the Geisinger health care system. The parent entity is an IRC 501(c)(3) organization that controls GHP and several IRC 501(c)(3) hospitals, clinics, and other health care organizations. GHP offers prepaid health care plans to both individual and group subscribers. It contracts with other entities in the Geisinger system to perform the actual health care services; GHP performs no medical services itself. GHP also contracts with entities outside the Geisinger system such as hospitals, physicians, and pharmacies to provide services to subscribers. GHP reimburses the hospitals and clinics by paying a negotiated per diem charge for inpatient services and a discounted percentage of billed charges for outpatient services.

GHP does not arrange for or provide care to nonsubscribers. It offers virtually no indigent care, no emergency room, no staff, nor any facilities available to the community other than to its subscribers. As of 1988, the percentage of the membership who were individual enrollees was relatively small (6%), and there had been no overt effort to increase individual memberships. While there was to be a subsidized dues program, it would have benefited only one-half of one percent of subscribers.

The Service determined that, although GHP does not provide commercial-type insurance, and thus is not denied exemption by IRC 501(m), it nevertheless failed to qualify for IRC 501(c)(3) exemption because it primarily benefits its subscribers rather than the community.

In reversing a Tax Court decision in favor of GHP (62 TCM 1656), the Third Circuit distinguished GHP from the organization held to be exempt in Sound Health. While not endorsing a strict application of the multi-factor test set forth above to determine whether an HMO may qualify for IRC 501(c)(3) exemption, the court stated that the determination should be based upon whether all the circumstances show that the HMO benefits the community in addition to its subscribers. Noting that GHP provides no health care services itself and does not ensure that nonsubscribers have access to health care or information about health care, and noting further that GHP conducts no research and offers no educational programs for the public, the court found that GHP benefits no one but its subscribers.

The mere presence of a subsidized dues program, which would help additional persons to afford membership, was not sufficient to persuade the court that GHP operates in a charitable manner. While such a program strongly influenced the Tax Court in Sound Health, the Geisinger court criticized the weight that the Tax Court in Sound Health placed upon the subsidies. The Third Circuit stated that the relevant inquiry was not whether the HMO benefited the community at all, but whether it primarily benefited the community. The case was remanded to the Tax Court for a determination whether GHP could qualify for IRC 501(c)(3) exemption based upon its alternative argument that it is an "integral part" of the Geisinger system.

C. Integral Part

G.C.M. 39830 (Aug. 30, 1990) concludes that a separately incorporated non-staff model HMO that is controlled by a tax exempt parent of a nonprofit health care system, and that does not qualify for IRC 501(c)(3) exemption on its own, cannot qualify for exemption as an integral part of the parent.

In order to qualify for exemption as an integral part of an IRC 501(c)(3) organization, G.C.M. 39830 notes that two elements are necessary:

(1) the organizations must be structurally or financially related; and

(2) the subordinate entity must perform essential services for the parent.

The element of structural relatedness, which is derived from Reg.. 1.502-1(b), was not at issue in G.C.M. 39830. Sufficient control and supervision of the HMO by the parent organization was clearly present to ensure a finding that the organizations were structurally related. The key issue in G.C.M. 39830 was whether the organization's HMO activities constituted services essential to the tax exempt parent and to the parent's hospital system.

Although conceding that the HMO provided some benefit to the exempt hospital system to the extent that it attracted more patients to the hospital through its service contracts, G.C.M. 39830 stated that the HMO primarily served its member-subscribers rather than the parent or the hospital system. Further, its activities should be characterized as providing services to selected individuals including an insurance-type benefit. As such, the G.C.M. concluded that substantial private benefit was conferred on the member-subscribers. This class of persons was simply not broad enough to allow a finding that the HMO benefitted the community as a whole.

The G.C.M. also questioned whether the insurance-type services that an HMO provides can be considered as essential to a hospital as most hospitals do not operate HMOs. It concluded that any benefit to the hospital was merely incidental to the benefit conferred upon the HMO's member-subscribers.

Finally, the G.C.M. concludes that the integral part rationale does not extend to cases where the services of the subordinate entity are delivered to third parties (the member-subscribers) rather than to the parent hospital system or to patients of the hospital system. Where services are provided to third parties, the activities constitute unrelated trade or business rather than essential services to the hospital system.

The Tax Court's decision in Geisinger Health Plan v. Commissioner, 100 TC No. 26 (May 3, 1993), on remand from the Third Circuit, was consistent with G.C.M. 39830. Noting that the higher court had found that GHP primarily benefited its subscribers, the Tax Court stated that unless the class of member-subscribers substantially overlapped the class of hospital patients, the integral part rationale was not available to confer exemption upon GHP. The court found no such overlap and held that GHP had not sustained its burden of proving

that it was entitled to exemption under IRC 501(c)(3).

This decision has been appealed by the taxpayer to the Third Circuit where oral argument was held May 19, 1994.

4. Parent Organization Issues

A. In General

The 1980's biggest development in tax exempt health care was the reorganization of hospitals into systems. These systems typically consist of a parent organization with a number of tax exempt and for-profit subsidiaries. Questions arose regarding the tax exempt and private foundation status of the parent organizations. These were addressed in G.C.M. 39508 (May 27, 1986).

G.C.M. 39508 analyzes whether the parent organization qualifies as an IRC 509(a)(3) supporting organization. In determining whether the parent is "supervised or controlled in connection with" the IRC 509(a)(1) or (2) organizations it supports or benefits, the Service must determine whether control or management in the supporting organization (the parent) is, in the words of Reg. 1.509(a)-4(h)(1), "vested in the same persons" that perform such functions for each IRC 509(a)(1) or (2) organization that it supports. The G.C.M. indicates that no less than a majority of the persons who control or manage the supporting organization must have the "requisite commonality" with the persons performing the same functions for each and every IRC 509(a)(1) or (2) organization that is supported or benefitted for the organization to qualify as an IRC 509(a)(3) supporting organization.

A question that G.C.M. 39508 explicitly left unresolved, however, was whether a parent could provide services to its taxable subsidiaries and still qualify for IRC 509(a)(3) classification. (In a typical system, a parent provides strategic planning and management services to its taxable subsidiaries, as well as to its tax exempt ones, offering the services at the same cost to all.)

The National Office encouraged development of this issue in the early round of hospital CEP examinations. Two well-developed technical advice requests from the Southwest region asked whether a parent of a hospital system that had taxable subsidiaries should be treated as a private foundation because it did not, as Reg. 1.509(a)-4(e)(1) literally requires, solely support specified publicly supported organizations. After a thorough consideration of the issue by

senior National Office officials, a decision was made to seek a regulatory or legislative solution. Therefore, the cases were returned to the field. It should be noted that the tax proposals submitted to Congress with the Clinton Administration's health care reform package contain a new IRC 509(a)(4) that, if enacted, would statutorily classify such parent organizations as nonprivate foundations. In the interim, the Service is continuing to apply the administrative ruling position it applied during the 1980's.

B. Super-Parent Organizations

On September 1, 1993, the Service issued a ruling recognizing Northwestern Healthcare Network as an exempt organization described in IRC 501(c)(3). The ruling also determined that the organization was not a private foundation within the meaning of IRC 509(a) because it was an IRC 509(a)(3) supporting organization. Letter to Northwestern Healthcare Network (Sept. 1, 1993) reprinted in Exempt Organizations Tax Review, October 1993, Vol. 8, No. 4, P. 799. The organization was created as part of an affiliation among several existing hospital systems to act as the "Super-Parent" of a regional network. The various participating organizations had previously been recognized as exempt from federal income tax as IRC 501(c)(3) organizations. Three of the four participating organizations were the IRC 501(c)(3)/509(a)(3) parents of hospital systems that included taxable and exempt subsidiaries. The fourth participating organization directly operated exempt hospitals. The structure of the network is illustrated below:

[Chart not reproduced in this document]

The affiliation is intended to create a regional, academic and research-oriented, health care network affiliated with Northwestern University. The ruling states that the affiliation is designed to do the following:

(1) Coordinate the provision of patient care services which should reduce duplication of resources and allow delivery of more cost-efficient care;

(2) Offer more specialized services to a larger patient base;

(3) Provide participants of the network with enhanced clinical, research, marketing, planning, finance, and organizational services and expertise on a regional basis;

(4) Improve and enhance the strategic planning for the affiliated hospital systems as a whole on a regional basis;

(5) Enhance access to capital markets at lower costs for the affiliated hospital systems;

(6) Provide access to the most recent technological and medical advances;

(7) Promote the education of physicians and other health care professionals; and

(8) Advance science through research regarding the cure and treatment of human disease and other medical and scientific matters by the affiliation of the hospitals with an academic institution.

The organization is managed by a Council of Governors. The four affiliating hospital systems each appoint seven individuals to the Council, at least four of whom must be officers, directors, or medical staff physicians of the hospitals and at least one of which is a medical staff physician of the hospital. No more than 20 percent of the Council may be physicians affiliated with any of the affiliated hospitals for purpose of providing medical services. The Council of Governors has the authority to (1) appoint the directors of the organization; (2) remove the directors for cause; (3) approve amendments to the Articles of Incorporation; (4) approve certain extraordinary acts with respect to the organization, such as a merger, consolidation, or the sale, lease, exchange or other disposition of all or substantially all of the organization's assets; and (5) approve of the actions of the participating organizations with respect to the withdrawal or expulsion of a participating organization from the affiliation, or the dissolution of the organization.

Day-to-day management of the organization is provided by its Board of Directors. The Board of Directors is elected by the Council of Governors and, for the first five years, will include the President of Northwestern University, the President and CEO of the organization, and the chairmen of each of the participating organizations, or their designees, as ex-officio voting directors, along with one other representative from each of the boards of the participating organizations. After the first five years, other than the ex-officio directors, no

member of the organization's board will also be a member of the board of one of the affiliated organizations.

The organization has the power to appoint the directors of the participating organizations and remove them for cause. The organization must approve any amendment to the articles or bylaws of the participating organizations that affect the affiliation relationship. The organization can expel from the affiliation any participating organization, must approve the withdrawal from affiliation of any participating organization, and must approve the addition of any new participating organization to the affiliation upon its meeting certain minimum requirements.

The organization was recognized as an IRC 501(c)(3) organization on the basis that it operated as an integral part of the supported organizations. By providing the overall management and coordination services for the system, the organization is serving an essential function of the supported organizations. In addition, the organization is structurally related to the supported organizations through the control exercised by the Council of Governors over the participating organizations. In addition, the organization qualified as an IRC 509(a)(3) supporting organization because it was supervised or controlled in connection with the supported organizations. Control and management of the organization is vested in the same persons who control and manage the supported organizations.

5. Joint Venture Issues

A. G.C.M. 39862

G.C.M. 39862 (Nov. 22, 1991), reconsidered three private letter rulings approving specific hospital-physician joint ventures involving a sale of part of the hospitals' net revenue streams. The G.C.M. analyzes the transactions for inurement and private benefit and concludes that the net revenue stream transactions jeopardize the tax exempt status of the participating hospitals. The G.C.M. is discussed fully in the 1993 EO CPE text at p. 166.

In the wake of G.C.M. 39862, the Service announced that it would consider, for a limited time, resolution of tax exemption issues arising from gross or net revenue stream joint ventures between hospitals and their medical staffs, if the hospitals terminated the agreements without further inurement or private benefit to the physician-investors. Announcement 92-70, 1992-19 I.R.B. 89, provided that the Service would review requests to enter into closing agreements or other arrangements regarding such transactions if the requests were made by September

1, 1992. As a result of the announcement, more than 10 hospitals entered into arrangements with the Service. In all cases, the net revenue stream transaction was undone, usually with the hospital's repurchase of the revenue stream from the joint venture, and the hospitals retained their exempt status.

B. Other Joint Ventures

The determination that net revenue stream joint ventures will result in inurement and impermissible private benefit to the participating physicians does not mean that hospitals may not enter into joint ventures with nonexempt entities. In recent private letter rulings, the Service has ruled that tax exempt hospitals did not jeopardize their exemption when they entered into joint ventures with for-profit corporations. Three of the rulings specifically provided that the joint venture facility would serve Medicare and Medicaid patients and would have an open medical staff and made some provision for charity care (one would provide services without regard to patient's ability to pay, one would operate a 24-hour emergency room open to all regardless of ability to pay, and the third would make a certain number of beds available for charity care). All the rulings found that the transactions would benefit the community by improving the quality of care, the increasing efficiency of operation of a particular department, or the expanding services for a particular specialty. Although the tax exempt organizations would not exercise day-to-day control over the operations of the joint ventures, they had sufficient control to ensure that the operation of the joint ventures would continue to benefit the community and otherwise serve to further the tax exempt hospital's charitable purposes. The tax exempt hospitals would contribute fair market value to the ventures, as determined in arms' length negotiations, and would not be putting their charitable assets at risk in entering into the arrangement and profits from the joint ventures would be allocated in accordance with equity interests. Thus, the private benefit to the for-profit corporations was incidental to the community benefit. PLR 93-08-034 (November 30, 1992) (operation of an acute care hospital); PLR 93-18-033 (February 8, 1993) (operation of combined orthopedic facility); PLR 93-23-030 (March 16, 1993) (construction and operation of rehabilitation hospital); and PLR 93-52-030 (October 8, 1993) (expansion of rehabilitation facility).

C. Unwinding Joint Ventures

Physicians have for several years been prohibited from referring Medicare patients to clinical laboratories in which they (or immediate members of their families) have a financial interest. In 1993, Congress extended this prohibition to

apply to Medicaid as well as Medicare. In addition, Congress expanded coverage to prohibit referrals to entities in which the physician (or immediate family members of the physician) have a financial relationship for a list of designated health services. Designated health services consist of the following: clinical laboratory services; physical therapy services; occupational therapy services; radiology or other diagnostic services; radiation therapy services; durable medical equipment; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. (Omnibus Reconciliation Act of 1993, 13562). These provisions go into effect for referrals after December 31, 1992, for clinical laboratory services and for referrals after December 31, 1994, for all other designated health services.

A substantial number of joint ventures between hospitals and physicians had previously been entered into to provide such services. Many of these are now being terminated to avoid the referral restriction. In some cases, the hospital may choose to (or be pressured to) buy out the interests of the physicians. These transactions must be carefully reviewed for potential inurement and private benefit problems. The sellers may pressure the hospital to pay more than the fair market value of the tangible assets, raising difficult valuation, exemption, and Medicare fraud and abuse issues. In particular, the value of any goodwill for the joint venture once physician investors leave the venture may be nonexistent since the value largely derives from the physicians as a continuing source of referrals.